

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-048787

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **3184**

Primary Registration District No. **1003**

Registrar's No. **12450**

STATE FILE NUMBER

**FILED JAN 10 1963**

VS 300 Rev. 4/59	DATE AMENDED
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2400x30	
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1265-0	
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65	INSTEAD OF
	BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>Overland</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>9133 Brownridge</b>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <b>Carrie</b> Middle <b>F.</b> Last <b>Swallow</b>		Month <b>Dec.</b> Day <b>26th</b> Year <b>1962</b>	
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH
<b>Female</b>	<b>White</b>		<b>4-11-1888</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)
<b>Retired Housewife</b>		<b>Own Home</b>	<b>Quincy Ill.</b>
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
<b>Jacob Kreher</b>		<b>Unknown</b>	<b>Joseph Swallow</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
<b>(No)</b>		<b>None</b>	<b>Dr. H. Jenkins, Star Route, St. Clair, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Arterio-sclerotic heart disease</b>			<b>8 mo.</b>
DUE TO (b) <b>Arterio-sclerosis</b>			<b>10 yrs.</b>
DUE TO (c) <b>420.0</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days.
<b>Diabetes mellitus</b>			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY	Hour	Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION
			COUNTY
			STATE
21. I attended the deceased from <b>12/8/62</b> to <b>12/24/62</b> and last saw her alive on <b>12/24/62</b>			
Death occurred at <b>2:05 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title)		22b. ADDRESS	22c. DATE SIGNED
<b>Edward W. Gabundhi, MD</b>		<b>3701 Grand St</b>	<b>12/26/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<b>Removal</b>	<b>12-28-1962</b>	<b>Laurel Hill Gardens</b>	<b>St. Louis Co. Mo.</b>
24. FUNERAL DIRECTOR		25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
<b>JAY B. SMITH, Maplewood, Mo.</b>		<b>DEC 27 1962</b>	<b>Loan Smith, M.D.</b>

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

MEDICAL CERTIFICATE

DATE AMENDED

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

DATE AMENDED

DATE AMENDED

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed W. H. Burgess

Licensed Embalmer No. 4029

P. O. Address Maplewood

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.